

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3622

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 116

03610

1. PLACE OF DEATH - COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge		CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge Md. Hospital		STREET ADDRESS (If rural, give location) 20 Moores Avenue	
3. NAME OF DECEASED (First) WALTER (Middle) BENNETT (Last) BENNETT		4. DATE OF DEATH (Month) April (Day) 1 (Year) 1955	
5. SEX Male	6. COLOR OR RACE Negro	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 4, 1873 81 yrs. 9 Months 27 Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Food Packing	11. BIRTHPLACE (State or foreign country) St. Marys County, Md.
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		17. INFORMANT AND ADDRESS Inez Opher, Cambridge, Maryland	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) Carcinoma of prostate			1 year
Antecedent cause(s) (b) Cardiac decompensation			3 mos
(c) Arteriosclerotic Heart Disease			7 years
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. Gangrene of rt. foot			1 month
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, OF INJURY INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Jan 3, 1955 , to Apr 1, 1955 , that I last saw the deceased alive on Apr 1, 1955 , and that death occurred at 8:20 a.m. , from the causes and on the date stated above.			
SIGNATURE Alfred R. Maryano		(Degree or title) M.D.	ADDRESS 136 Rice St., Cambridge DATE SIGNED 4/1/55
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 4/5/1955	NAME OF CEMETERY OR CREMATORY Madison Cemetery	LOCATION (City, town, or county) (State) Cambridge, Maryland
DATE REC'D BY LOCAL REG. 4-4-55	REGISTRAR'S SIGNATURE John Mace Jr. M.D.	24. FUNERAL DIRECTOR Herbert M. St. Clair, Jr., Cambridge, Md.	

RECEIVED

APR 7 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3635 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03611

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Cambridge</u>		1 mo. 21 days		TOWN <u>Bethlehem</u> 05 X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>EASTERN SHORE STATE HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>-----</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)				
(Type or Print) <u>Frederick</u> --- Birth			OF DEATH: <u>April 14 1955</u>				
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Sep.</u>	<u>11-21-1898</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>---</u>		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Frederick Birth</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Renner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk.</u>			16. SOCIAL SECURITY No. <u>---</u>		17. INFORMANT & ADDRESS: <u>RECORDS: Eastern Shore State Hospital</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchial Asthma</u>			DUE TO				20 yrs.
ANTECEDENT CAUSE (B) <u>Hypertension</u>			DUE TO				over 1 mo.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Coronary Thrombosis</u>							15 minutes
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>2-24</u> , 19 <u>55</u> , to <u>4-14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-13</u> , 19 <u>55</u> , and that death occurred at <u>1:25</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Harry J. Crawford</u>			ADDRESS <u>M. D. 255 Hop Cambridge Ind</u>			DATE SIGNED <u>APR 14 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>APR 17 1955</u>		<u>PRESTON CEMETERY</u>		<u>CAROLINE COUNTY MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-14-55</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>W. Brampton Carroll</u>		ADDRESS <u>Easton, MD</u>	

BUREAU V. S.

APR 18 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3638

03612

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Town</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>East New Market</u>		TOWN <u>East New Market</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Egypt Road</u>				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Albanus</u>		(Middle)		(Last) <u>Brannock</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April 9, 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Sept. 18, 1927</u>	9. AGE last birthday: <u>27</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>general labor</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Rufus Brannock</u>				14. MOTHER'S MAIDEN NAME: <u>Mary F. Travers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		(If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY No.: <u>218-20-6359</u>		17. INFORMANT & ADDRESS: <u>Margie Ennals, Cambridge, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>823X</u> Immediate cause (a) <u>Intra cranial injury</u> DUE TO Antecedent cause(s) (b) <u>Depressed fracture frontal bone</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>30 min.</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Egypt Road</u>		21c. (City or town) (County) (State) <u>nr. Cambridge, Dorchester Maryland</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>4-9-55 5 A M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Car overturned and pinned body under car.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>John Macfarland</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>April 13, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Taylors Island</u>		LOCATION (City, town, or county) (State) <u>Taylors Island, Md.</u>	
DATE REC'D BY LOCAL REG. <u>4-11-55</u>		REGISTRAR'S SIGNATURE <u>John Macfarland</u>		24. FUNERAL DIRECTOR <u>H. M. St. Clair, Jr.</u>		ADDRESS <u>Cambridge, Md.</u>	

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APR 15 1955

BUREAU V. S.

3631

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03613
Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland COUNTY Dorchester			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN (Rural) Cambridge		Life		TOWN (Rural) Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				R.F.D. #2			
3. NAME OF DECEASED: (First) HOWARD		(Middle) WINFIELD		(Last) CHESTER		4. DATE OF DEATH April 14 1955	
5. SEX: Male		6. COLOR OR RACE: Negro		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: April 22, 1897	
9. AGE last birthday: 57 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer		11. BIRTHPLACE (State or foreign country): Dorchester County, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Robert Chester				14. MOTHER'S MAIDEN NAME: Harriett Jackson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) -----				16. SOCIAL SECURITY No.: 164-05-8741		17. INFORMANT & ADDRESS: Sarah F. Chester, Cordtown, Dor. Co., Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						5 min.	
Immediate cause (a) Coronary occlusion							
DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>John Mace Jr.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4-15-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF 4/18/1955		NAME OF CEMETERY OR CREMATORY Cordtown Cemetery		LOCATION (City, town, or county) (State) Cordtown, Dor. Co., Maryland	
DATE REC'D BY LOCAL REG. 4-15-55		REGISTRAR'S SIGNATURE <i>John Mace Jr. M.D.</i>		24. FUNERAL DIRECTOR Herbert M. St. Clair, Jr., Cambridge, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3623 CERTIFICATE OF DEATH

03614

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>19 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17 Locust Street</u>				STREET ADDRESS (If rural give location) <u>17 Locust Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ESTHER</u> <u>SMULOWITZ</u> <u>FELDMAN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 11</u> <u>1955</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>12-17-94</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Coatsville, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Isaac Smulowitz</u>				14. MOTHER'S MAIDEN NAME: <u>Hanna Myers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>220-12-0289</u>		17. INFORMANT & ADDRESS: <u>Mr. Irwin Feldman, Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Uremia</u>						<u>1 Month</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Secondary anemia (severe)</u>						<u>3 Months</u>	
(C) <u>Generalized Carcinomatosis of rt. breast</u>						<u>Approx. 8 Months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Parkinson's Syndrome</u>						<u>4 Years</u>	
19A. DATE OF OPERATION: <u>1949</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Radical of right breast for cancer on right breast</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8-17</u> , 19 <u>51</u> , to <u>4-11</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4-10</u> , 19 <u>55</u> , and that death occurred at <u>12:55</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Edridge H. Sheffield</u>		M. D. <u>Cambridge, Maryland</u>		DATE SIGNED <u>4-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-12-55</u>		NAME OF CEMETERY OR CREMATORY <u>Hebrew Friendship</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-11-55</u>		REGISTRAR'S SIGNATURE <u>John Macer</u>		24. FUNERAL DIRECTOR <u>Jack Lewis, Baltimore, Maryland</u>		ADDRESS	

FilmG180 4-15-55 Two for one certificate

BUREAU V. S.

APR 15 1955

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3624

03615

Reg. Dist. No. 116

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13 TOWN Cambridge</u>		LENGTH OF STAY (in this place) <u>3 days</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR <u>TOWN Cambridge</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6.7 Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural, give location) <u>Meadow Avenue</u>			
3. NAME OF DECEASED: (Type or Print) <u>ROBERT</u>		(First) <u>KENNEL</u>		(Middle) <u>GOOTEE</u>		(Last)	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>		8. DATE OF BIRTH: <u>12-7-1882</u>	
9. AGE last birthday: <u>72 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Janitor</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John W. Gootee</u>				14. MOTHER'S MAIDEN NAME: <u>Martha S. Sellers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u>		16. SOCIAL SECURITY No.: <u>not known</u>		17. INFORMANT & ADDRESS: <u>William C. Gootee : Cambridge, Maryland</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
332X Immediate cause (a) <u>Cerebral Thrombosis</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)						<u>3 days</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town)		(County)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>. SIGNATURE <u>John Mace</u> M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-18-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4-18-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>4-18-55</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

RECEIVED

APR 20 1955

BUREAU V. S.

MARYLAND

3638

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. *112*

1. PLACE OF DEATH- COUNTY <i>Dorchester</i>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Dor.</i>	
CITY (If outside corporate limits, write BURAL and OR give nearest town) <i>Callistis</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Callistis</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>—</i>		STREET ADDRESS (If rural, give location) <i>—</i>	
3. NAME OF DECEASED (Type or Print) (First) <i>Clara</i> (Middle) <i>Emily</i> (Last) <i>Grady</i>		4. DATE OF DEATH (Month) <i>4</i> (Day) <i>3</i> (Year) <i>1955</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>Married</i>	8. DATE OF BIRTH <i>5/22/1868</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>	9. AGE last birthday <i>86</i> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <i>Clayton Moore</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. MOTHER'S MAIDEN NAME <i>Joshua Liggins</i>		14. MOTHER'S MAIDEN NAME <i>—</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <i>—</i>	
17. INFORMANT AND ADDRESS <i>Mrs. Brady C. Well, Callistis, Md.</i>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
450.0 Immediate cause (a) <i>Coronary Heart failure.</i>		
Antecedent cause(s) (b) <i>Pneumonia, lobular, bilateral</i>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>arterio sclerosis, generalized</i>		7 days 7 days ?
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>marked cerebral changes</i>		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *1952*, to *Apr 3*, 1955, that I last saw the deceasedalive on *Apr 2*, 1955, and that death occurred at *2:30 a.m.*, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

<i>James C. Thompson</i>	<i>M.D.</i>	<i>Cambridge, Md.</i>	<i>Apr. 4, 55</i>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<i>Buried</i>	<i>4/6/55</i>	<i>East New Market</i>	<i>East New Market, Md.</i>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<i>April 4-55</i>	<i>Elizabeth W. Craft</i>	<i>Edith S. Willoughby</i>	<i>East New Market, Md.</i>

MARGIN RESERVED FOR BINDING

RECEIVED

APR 6 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3639

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03617

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge,</u>		LENGTH OF STAY (in this place) <u>1 mth and 3</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Taylors Island</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Shore State Hosp.</u>				STREET ADDRESS (If rural give location) <u>--</u>			
3. NAME OF DECEASED: (First) <u>Angelina</u> (Middle) <u>Virginia</u> (Last) <u>Grimes</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 27 19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>8-8-1881</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 1 YEAR Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>--</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.</u>
13. FATHER'S NAME: <u>Samuel Grim</u>				14. MOTHER'S MAIDEN NAME: <u>Emily Sherman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>--</u>			16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS: <u>Eastern Shore State Hospital Records</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia</u>						<u>6 days</u>	
DUE TO							
ANTECEDENT CAUSE (B) <u>Generalized Arteriosclerosis</u>						<u>Several yrs.</u>	
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Chronic Myocarditis</u>						<u>Several yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Psychosis with Cerebral Arteriosclerosis</u>						<u>about 2 yrs.</u>	
19A. DATE OF OPERATION: <u>--</u>			19B. MAJOR FINDINGS OF OPERATION: <u>--</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>--</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>--</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>--</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>--</u>			
22. I hereby certify that I attended the deceased from <u>March 24, 1955</u> , to <u>April 27, 1955</u> that I last saw the deceased alive on <u>April 27</u> , 19 <u>55</u> and that death occurred at <u>3:23 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Robert H. Reddick</u>		M.D. <u>Cambridge, Md.</u>		DATE SIGNED <u>4/27/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/30/55</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		LOCATION City, town, or county (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4/28/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>[Address]</u>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3625
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03618
Reg. Dist.

No. 116

1. PLACE OF DEATH: COUNTY Dorchester MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) Cambridge TOWN Cambridge HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge - Maryland Hospital				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Dorchester CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Cambridge STREET ADDRESS (If rural, give location) 701 Radiance Drive			
3. NAME OF DECEASED: (Type or Print) Edna		(First) L. (Middle) Hinman (Last)		4. DATE OF DEATH April 9 19 55			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed			
8. DATE OF BIRTH: April 23, 1892		9. AGE last birthday: 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Nurse			
11. BIRTHPLACE (State or foreign country): Millington, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME: Harry Dulin			
14. MOTHER'S MAIDEN NAME: Dora Duling		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 213-14-4778			
17. INFORMANT & ADDRESS: William W. VanSant, Elkton, Maryland		18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 420.1 Immediate cause (a) Coronary occlusion Antecedent cause(s) (b) DUE TO Diseases or conditions, if any, giving rise to the above cause DUE TO stating <u>underlying cause last</u> (c)				INTERVAL BETWEEN ONSET AND DEATH 2 hrs.			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
21a. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21b. (City or town) (County) (State)		21c. HOW DID INJURY OCCUR?			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE John M. Mace		M. D. John M. Mace		DATE SIGNED 4-9-55			
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF April 13, 1955		NAME OF CEMETERY OR CREMATORY Millington Cemetery			
LOCATION (City, town, or county) (State) Millington, Md.		24. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.		ADDRESS			
DATE REC'D BY LOCAL REG. 4-9-55		REGISTRAR'S SIGNATURE John M. Mace		25. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.			

RECEIVED

APR 15 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3626

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03619

CERTIFICATE OF DEATH

Reg. Dist. No. 116

Item 7. Film 181 5-3-55 et

1. PLACE OF DEATH COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) 13 TOWN <u>Cambridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Cambridge</u> 13	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 <u>16 Hubbard Street</u>		STREET ADDRESS (If rural, give location) <u>16 Hubbard Street</u> 1	
3. NAME OF DECEASED (Type or Print) <u>William</u>	(First) (Middle) (Last)	4. DATE OF DEATH <u>April 19</u> 19 <u>55</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Unknown</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	9. AGE last birthday <u>68</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Josephine Joshua</u>		14. MOTHER'S MAIDEN NAME <u>Josephine Joshua</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>unk.</u>	
17. INFORMANT <u>Mable Light, Cambridge, Maryland</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) <u>Cardiac Decompensation</u>			
Antecedent cause(s) (b) <u>Hypertensive Arteriosclerotic heart disease</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office hldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Nov 15, 1954, to Apr 19, 1955, that I last saw the deceased alive on April 19, 1955 and that death occurred at 11 P.m., from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

J. EDWIN FASSETT, M.D. - 227 Pine St - Cambridge, Md. - April 22, 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>April 20</u>	NAME OF CEMETERY OR CREMATORY <u>Bayview</u>	LOCATION (City, town, or county) <u>Dorchester</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>April 25, 1955</u>	REGISTRAR'S SIGNATURE <u>John M. M. D.</u>	2. FUNERAL DIRECTOR <u>Bayview</u>		ADDRESS <u>James 222 Cedar</u>

RECEIVED

APR 26 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3640
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04602
 Reg. Dist.

No. 110

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN Rhodesdale		LENGTH OF STAY (In this place) Life		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Rhodesdale X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Maryland Route #331				STREET ADDRESS (If rural, give location) 1			
3. NAME OF DECEASED: (Type or Print)		(First) Leonard		(Middle)		(Last) Johnson	
5. SEX: Male		6. COLOR OR RACE: Colored		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single		8. DATE OF BIRTH: May 10, 1918	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Day Laborer		10b. KIND OF BUSINESS OR INDUSTRY: Farm		9. AGE last birthday: 36 yrs.		4. DATE OF DEATH (Month) (Day) (Year) April 23 1955	
11a. BIRTHPLACE (State or foreign country): Dorchester Co., Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME: Levin Stanley				14. MOTHER'S MAIDEN NAME: Sadie Johnson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: Unknown		17. INFORMANT & ADDRESS: Emily Washington, Federalsburg, Md., R.F.D.	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
812X Immediate cause (a) Severance of Cervical Cord DUE TO							April 5 min.
Antecedent cause(s) (b) Fracture of Cervical Spine DUE TO							4 5 min.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Trauma of auto accident							4 5 min.
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: Probable head injury, Acute alcoholism 0.35% 7 feet walk							11 5 min.
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway		21c. (City or town) (County) (State) Rhodesdale Dorchester Md.			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 4 23 55 7:45 P.M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? Reckless Struck by auto			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE Eldridge H. Voelker		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. 4-29-55					
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF April 26, 1955		NAME OF CEMETERY OR CREMATORY Saul Landing Cemetery		LOCATION (City, town, or county) (State) Near Vienna, Maryland	
DATE REC'D BY LOCAL REG. April 26-1955		REGISTRAR'S SIGNATURE Charles Hartings		24. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.		ADDRESS	

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 112

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN		X	
TOWN <u>Vienna</u>		<u>50 yrs</u>		TOWN <u>Vienna</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>on boat in Nanicoke River</u>				STREET ADDRESS (If rural, give location) <u>/</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>William</u>		(Middle) <u>James</u>		(Last) <u>Jones</u>	
4. DATE OF DEATH		(Month) <u>April</u>		(Day) <u>2</u>		(Year) <u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
<u>male</u>	<u>white</u>	<u>married</u>	<u>3/12/1879</u>	<u>76</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Carpenter</u>		<u>Self-employed</u>		<u>Virginia</u>		<u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Jones</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah J. Price</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs William J. Jones Sr, Vienna</u>			
(If Yes, give war or dates of service)							

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				<u>5 min.</u>	
<u>420.1</u>					
Immediate cause		(a) <u>Coronary occlusion</u>			
DUE TO					
Antecedent cause(s)		(b)			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO			
(c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>John Mace Jr.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-4-55</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial near Cambridge, Md.</u>	
LOCATION (City, town, or county) (State)		24. FUNERAL DIRECTOR <u>Keith S. Holloway</u>		ADDRESS <u>East New Market, Md.</u>	
DATE REC'D BY LOCAL REG. <u>April 4-55</u>		REGISTRAR'S SIGNATURE <u>Elizabeth H. Craft</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

13

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3627

03621
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 116

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Dorchester</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Dorchester</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Cambridge</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cambridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>High Street</u>		STREET ADDRESS (If rural, give location) <u>Leonard Lane</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Isabella</u> <u>Kiah</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>April</u> <u>27</u> , 19 <u>55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>9-22-1909</u>
9. AGE last birthday: <u>45</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>general</u>	
11. BIRTHPLACE (State or foreign country): <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John W. Todd</u>		14. MOTHER'S MAIDEN NAME: <u>Susanna Travers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>218-20-2757</u>	
17. INFORMANT & ADDRESS: <u>Luther Kiah, Leonard Lane Cambridge</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		1 hr.
<u>331X</u> Immediate cause (a) <u>Cerebral hemorrhage</u> DUE TO Antecedent cause(s) Diseases or conditions, if any, (b) <u>giving rise to the above cause</u> stating underlying cause last (c) <u>stating underlying cause last</u>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>John Mace</u> John Mace, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-30-55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>4-30-55</u>	NAME OF CEMETERY OR CREMATORY <u>Rock Cemetery</u>
LOCATION (City, town, or county) (State) <u>Rock, Maryland</u>	24. FUNERAL DIRECTOR	ADDRESS
DATE REC'D BY LOCAL REG. <u>4-30-55</u>	REGISTRAR'S SIGNATURE <u>John Mace, M.D.</u>	<u>Herbert M. St. Clair, Cambridge, Md.</u>

MEMORIAL EXAMINER'S COMPANIES FOR DEATH

BUREAU V. S.

MAY 3 1955

RECEIVED

03622

3642

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 110

1. PLACE OF DEATH COUNTY <u>Caroline</u> <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Virginia</u> COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Federalburg</u> LENGTH OF STAY <u>1 yr.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Melfa</u> 83X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u> (Middle) <u>Sewell</u> (Last) <u>Lane</u>	4. DATE OF DEATH	(Month) <u>4</u> (Day) <u>9</u> (Year) <u>1955</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>Oct. 27, 1875</u>
19a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	9. AGE last birthday <u>79</u> yrs. If under 1 year: Months Days Hours Min.
13. FATHER'S NAME <u>Norace S. Lane</u>		14. MOTHER'S MAIDEN NAME <u>Henrietta Kellern</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>SON - Charles S. Lane</u>	
17. INFORMANT		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
150x Immediate cause (a) <u>Emaciation, dehydration</u>			<u>1 Month</u>
Antecedent cause(s) (b) <u>Arteriosclerotic Cardiovascular Disease</u>			<u>10 yr.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Possible cancer of esophagus</u>			<u>1 yr.</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-28, 1955, to 4-9, 1955, that I last saw the deceased alive on 4-9, 1955, and that death occurred at 9:50 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>4-13-55</u>	<u>Mt. Holly Cem.</u>	<u>Onancock, Va.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>4-12-1955</u>	<u>Charles A. Hastings</u>	<u>Williams Fun. Home</u>	<u>Onancock Va</u>	

Phone 697

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

APR 14 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:

COUNTY Dorchester MARYLAND
 CITY (If outside corporate limits, write RURAL and give nearest town) Cambridge
 TOWN
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 15 Douglas Street

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Dor
 CITY (If outside corporate limits, write RURAL and give nearest town) Madison
 OR TOWN
 STREET ADDRESS (If rural give location) 1

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

AnnieL.Lee

4. DATE OF DEATH:

(Month)

(Day)

(Year)

April919 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

FemaleNegroWidowed Apr-2-188966

yrs.

0

Months

7

Days

0

Hours

010a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Laborer10b. KIND OF BUSINESS OR INDUSTRY: Food Packing11. BIRTHPLACE (State or foreign country): Dorchester-County-Md.12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

James H. Keene

14. MOTHER'S MAIDEN NAME:

Dorothy Carr

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 220-01-9132

17. INFORMANT & ADDRESS:

Hattie Lee-Madison, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause

(a)

Cardiac Decompensation

DUE TO

Antecedent causes(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

Arteriosclerotic Heart Disease

DUE TO

(c)

Interval Between Onset And Death

5 mos

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 9 Nov, 1954, to 9 Apr, 1954, that I last saw the deceased alive on 9 Apr, 1954, and that death occurred at 7 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

4-11-55John Mace Jr M.D.Herbert M. StClair, Jr., High St-Camb, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 15 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3628 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03624

CERTIFICATE OF DEATH

Item 8, Film 181 5-4-55 et

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>all life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge md</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 fairmount ave</u>				STREET ADDRESS (If rural give location) <u>fairmount ave</u>		<u>1</u>	
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>See</u> (Last) <u>(Lee)</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>April 8</u> 19 <u>55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>May 31 1884</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 1 HR. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <u>Labor</u>		11. BIRTHPLACE (State or foreign country): <u>Lincoln Road</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME: <u>John Bailey</u>				14. MOTHER'S MAIDEN NAME: <u>Fizzie Saunders</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Alphonse Phillip</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Stroke</u>						<u>6 wks</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma esophagus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>April 8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>April 8</u> , 19 <u>55</u> , and that death occurred at <u>6 P</u> M. from the causes and on the date stated above.							
SIGNATURE <u>W. Thompson</u>		M. D. <u>Cambridge md</u>		DATE SIGNED <u>4/11/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 12</u>		NAME OF CEMETERY OR CREMATORY <u>Walfield</u>		LOCATION (City, town, or county) (State) <u>Lincoln Road</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-11-55</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>W. H. Bayless</u>		ADDRESS <u>William James Jr</u>	

BUREAU V. S.

APR 15 1955

RECEIVED

3643

03625

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 116

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Dorchester		STATE	Maryland	
	MARYLAND		COUNTY	Cecil	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
X TOWN	Cambridge		OR TOWN	Elkton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	11 das.		STREET ADDRESS	(If rural, give location)	
16 Eastern Shore State Hospital			--		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Rebecca			April 6 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:		9. AGE last birthday:
F	W	Married	12-6-81		73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):
housewife			--		Delaware
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Hiram Pleasington			Elizabeth George		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			17. INFORMANT & ADDRESS:		
(If Yes, give war or dates of service) --			Eastern Shore State Hospital Records		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
904.7					
Immediate cause (a).....				3 days	
Terminal pneumonia					
DUE TO					
Antecedent cause(s) (b).....				42 days	
Fracture neck r. femur					
DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c).....					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				4 yrs.	
Senile psychosis					
19a. DATE OF OPERATION:				20. AUTOPSY?	
19b. MAJOR FINDING OF OPERATION:				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
Hospital		Cambridge		Dor. Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
2-23-55 M.				Slipped and fell.	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 4/9/55			
John Mac Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		4/9/55		Cherry Hill Md	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
4-7-55		John Mac Jr. M.D.		H. Walter DuBois Jr.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MINISTRE DU TRAVAIL
DEPARTMENT OF LABOUR

NOTIFICATION

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BUREAU V. S.

APR 11 1935

RECEIVED

03626

3629

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) OR 13 TOWN Cambridge		LENGTH OF STAY (in this place) 3 months		CITY (If outside corporate limits, write RURAL and give nearest town) OR 13 TOWN Cambridge			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 67 Cambridge-Maryland Hospital				STREET ADDRESS (If rural give location) 118 West End Ave.			
3. NAME OF DECEASED: (First) Albert (Middle) Edgar (Last) McCord				4. DATE (Month) (Day) (Year) OF DEATH: Apr. 25, 1955 19			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: Aug. 19, 1864	9. AGE last birthday 90 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer & Carpenter				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Bloomington, Indiana	
13. FATHER'S NAME: James McCord				14. MOTHER'S MAIDEN NAME: Sarah--last name unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no				16. SOCIAL SECURITY No. none		17. INFORMANT & ADDRESS: Joseph E. McCord, 118 West End Ave., Camb. Md.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) 442X Uremia		2 days
ANTECEDENT CAUSE (B) Cardioprenal vascular disease		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Arterio sclerosis.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertrophic prostate gland.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **4-16**, 19**55**, to **4-25**, 19**55**, that I last saw the deceased alive on **4-25**, 19**55**, and that death occurred at **11:19** M. from the causes and on the date stated above.

SIGNATURE **Albert Bunker** ADDRESS **Cambridge-Maryland** DATE SIGNED **4-26-55**

M. D. **Cambridge-Maryland**

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF Apr. 27, 1955	NAME OF CEMETERY OR CREMATORY Dorchester Memorial Park	LOCATION (City, town, or county) (State) Cambridge, Md.
DATE REC'D BY LOCAL REGISTRAR Apr. 27, 1955	REGISTRAR'S SIGNATURE John M. D.	24. FUNERAL DIRECTOR Kenneth R. Thomas, Cambridge, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 2 1955

RECEIVED

04610

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 110

3644

1. PLACE OF DEATH- COUNTY <u>Morchester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>MD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Williamsburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MD</u>	
TOWN <u>MD</u>		TOWN <u>MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>none</u>		STREET ADDRESS (If rural, give location) <u>MD</u>	
3. NAME OF DECEASED (Type or Print) <u>Sister Christy M. Mesford</u>		4. DATE OF DEATH (Month) <u>April</u> (Day) <u>29</u> (Year) <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>Mar. 11, 1877</u> 78 yrs.
9. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Delaware</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John C. Macon</u>	
14. MOTHER'S MAIDEN NAME <u>Alfonse</u> ? (last name unknown)		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>yes</u>		17. INFORMANT AND ADDRESS <u>Wm. Mesford - Williamsburg, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
153X Immediate cause			(a) <u>Intestinal obstruction (Carcinomatous)</u> 6 months
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			(b) <u>Carcinoma of Transverse Colon</u> 6mo. +
(c) <u>Carcinoma of liver</u>			6mo. +
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from <u>January 1955</u> , to <u>April 29, 1955</u> , that I last saw the deceased alive on <u>April 28, 1955</u> , and that death occurred at <u>6:00 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>W. C. Harrison MD</u>		ADDRESS <u>Hurlock, Md.</u> DATE SIGNED <u>4/29/55</u>	
23. BURIAL CREMATION REMOVAL (Specify)		DATE THEREOF <u>May 1, 1955</u> NAME OF CEMETERY OR CREMATORY <u>D.O.O.F. Cemetery</u> LOCATION (City, town, or county) (State) <u>Camden, Del.</u>	
DATE REC'D BY LOCAL REG. <u>April 29/1955</u>		24. FUNERAL DIRECTOR <u>Charles Hastings</u> ADDRESS <u>James Williams Federal</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 13 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3645

03627

Reg. Dist.

No. 115

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
<input checked="" type="checkbox"/> TOWN <u>Fishing Creek</u>		<u>life</u>		TOWN <u>Fishing Creek</u>		<input checked="" type="checkbox"/>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>P.O.</u>				STREET ADDRESS (If rural, give location) <u>P.O.</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH			
(First) <u>WILLIAM</u>		(Middle) <u>ARTHUR</u>		(Last) <u>PARKS</u>		(Month) (Day) (Year) <u>APRIL 29 19 55</u>	
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>7-31-1893</u>	
9. AGE last birthday: <u>61</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months Days		Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>Fishing Indust.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Zachariah Parks</u>				14. MOTHER'S MAIDEN NAME: <u>Sarah Jane Lewis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u> <u>yes</u> <u>W.W. Fin</u>				16. SOCIAL SECURITY No.: <u>220-09-1863</u>			
				17. INFORMANT & ADDRESS: <u>Mrs. Nellie C. Parks : Fishing Creek, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						1 hr.	
<u>331X</u> Immediate cause (a) <u>Cerebral Hemorrhage</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>James W. Meade</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>4-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>5-1-1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State): <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>5/2/55</u>		REGISTRAR'S SIGNATURE: <u>James W. Meade</u>		24. FUNERAL DIRECTOR: <u>LeCompte Funeral Service</u>		ADDRESS: <u>Cambridge, Maryland</u>	

BUREAU V. S.

MAY 9 1963

RECEIVED

3648

03628
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 110

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Dorchester		STATE	Maryland COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		
X TOWN Brookview	25 years		TOWN Brookview	X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE OF DEATH (Month) (Day) (Year)		
Arrow Aldred Thomas			April 15, 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
Male	White	Married	August 29, 1880	74	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Factory Employee			Phillips Packing Co.	Caroline Co., Md.	U.S.A.
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Tilghman H. Thomas			Mary E. Bowdle		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			17. INFORMANT & ADDRESS:		
No			Mrs. Grace M. Thomas, Rhodesdale, Md., R.D.		
16. SOCIAL SECURITY No.:			220-10-6174		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				Instant	
420.1 Immediate cause (a) Coronary occlusion DUE TO					
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE		M. D.		DATE SIGNED	
				4-15-55	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		LOCATION (City, town, or county) (State)	
Burial		April 17, 1955		Ridgely, Maryland	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
April 17-1955		Charles Hastings		J. J. Frampton, Federalsburg, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 21 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3630

CERTIFICATE OF DEATH

Reg. Dist. No.

03629

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13 Cambridge</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>13 Cambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 402 Henry Street</u>				STREET ADDRESS (If rural give location) <u>1 402 Henry Street</u>			
3. NAME OF DECEASED: (First) <u>CURTIS</u> (Middle) <u>LEE</u> (Last) <u>THOMAS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 7 1955</u>					
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>7-29-1894</u>	9. AGE last birthday <u>60 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Repairman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Carbonating Equipment</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>James N. Thomas</u>				14. MOTHER'S MAIDEN NAME: <u>Narrie Hill</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>not known</u>		17. INFORMANT & ADDRESS: <u>Mrs. Hattie Thomas : Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>2 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Hypertensive cardiovascular disease</u>						<u>1 year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/1/54</u> , 19 <u>54</u> , to <u>4/7/55</u> , that I last saw the deceased alive on <u>4/7/55</u> , and that death occurred at <u>10:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>M. D. LeCompte</u>		ADDRESS <u>Cambridge Md</u>		DATE SIGNED <u>4/10/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-10-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-11-55</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

RECEIVED

APR 18 1955

BUREAU V. S.

3631

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>2</u> days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Toddville</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>67</u> <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>P.O.</u> <u>1</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>LIDA</u> <u>MEREDITH</u> <u>TODD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>ARRIL</u> <u>14</u> <u>19</u> <u>55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11-11-1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Millard Meredith</u>				14. MOTHER'S MAIDEN NAME: <u>Georgia Meredith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT & ADDRESS: <u>Mrs. Hobart Mills; Toddville, Maryland</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>330X</u>				<u>23 Hours</u>			
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>7</u>			
(A) <u>Subarachnoid Hemorrhage</u>				<u>7</u>			
(B) <u>Arteriosclerosis</u>							
(C) <u>Hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/13</u> , 19 <u>54</u> , to <u>4/14</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>4/14</u> , 19 <u>55</u> , and that death occurred at <u>9 A</u> M, from the causes and on the date stated above. SIGNATURE <u>W. J. G. G. G.</u> ADDRESS <u>Cambridge Md</u> DATE SIGNED <u>4/15/55</u> M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-17-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-17-55</u>		REGISTRAR'S SIGNATURE <u>John Mace Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

BUREAU V. S.

APR 22 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03631

3632

CERTIFICATE OF DEATH

Reg. Dist. No. 116.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Dorchester</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>13</u> TOWN <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>42 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cambridge</u>		<u>13</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>302 Race Street</u>				STREET ADDRESS (If rural give location) <u>302 Race Street</u>		<u>1</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) DECEASED: <u>PAULA</u> <u>MACKENZIE</u> <u>TODD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL</u> <u>28</u> <u>19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>6-6-1888</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>		11. BIRTHPLACE (State or foreign country): <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Mackenzie</u>				14. MOTHER'S MAIDEN NAME: <u>Not Known</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>212-10-4571</u>		17. INFORMANT & ADDRESS: <u>Mr. Goodman Todd: Cambridge, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Carcinoma of left ovary & metastasis</u>						<u>5 years</u>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>April 1950</u>		19B. MAJOR FINDINGS OF OPERATION <u>Carcinoma of left ovary with metastasis</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr 3</u> , 19 <u>55</u> , to <u>Apr 28</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Apr 28</u> , 19 <u>55</u> , and that death occurred at <u>5⁴⁵ A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Refral R. Maryanov</u> ADDRESS <u>M. D. 136 Race St, Cambridge</u> DATE SIGNED <u>5/2/55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-30-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Cambridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>May 4, 1955</u>		REGISTRAR'S SIGNATURE <u>John Mace, m.d.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

BUREAU V. S.

MAY 9 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3647

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film 181 5-5-55 et

CERTIFICATE OF DEATH

03632

Reg. Dist. No. 115

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Dorchester		MARYLAND		STATE Maryland		COUNTY Dor.	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN Crapo		LENGTH OF STAY (in this place) 30 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Crapo X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rural				STREET ADDRESS (If rural give location) Rural			
3. NAME OF DECEASED: (First) (Middle) (Last) Martha Smith Wachsmuth				4. DATE (Month) (Day) (Year) OF DEATH: Apr. 12, 1955			
5. SEX: Female		6. COLOR OR RACE: White		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Widowed		8. DATE OF BIRTH:	
9. AGE last birthday 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		11. BIRTHPLACE (State or foreign country): Golden Hill, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Robert Smith				14. MOTHER'S MAIDEN NAME: Margaret Willey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS: Mrs. Ruby Wingate, Crapo, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Cerebral Hemorrhage						1 month	
ANTECEDENT CAUSE (S) (B) Hypertension 3, Anterior Cerebral Vessel disease						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) none							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none							
19A. DATE OF OPERATION: none				19B. MAJOR FINDINGS OF OPERATION: none			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? none		(Country) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY none		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? none			
22. I hereby certify that I attended the deceased from Jan 1953 , to 5/12, 1955 , that I last saw the deceased alive on April 12, 1955 , and that death occurred at 7:45 A.M. , from the causes and on the date stated above.							
SIGNATURE James W. Meade		ADDRESS M.D. Picking Creek, Md.		DATE SIGNED April 13/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 14, 1955		NAME OF CEMETERY OR CREMATORY Elzey Family Cemetery		LOCATION (City, town, or county) (State) Cambridge, Md.	
DATE REC'D BY LOCAL REGISTRAR April 13/55		REGISTRAR'S SIGNATURE James W. Meade		24. FUNERAL DIRECTOR ADDRESS Kenneth R. Thomas Cambridge, Md.			

BUREAU V. S.

APR 29 1955

RECEIVED

3633

CERTIFICATE OF DEATH

Reg. Dist. No. 116

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Dorchester</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Dorchester</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cambridge</u>		LENGTH OF STAY (in this place) <u>1 day</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dambridge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cambridge Maryland Hospital</u>				STREET ADDRESS (If rural give location) <u>304 Washington Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CINDY ELLEN WILLEY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>APRIL 1 19 55</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>11-10-1954</u>	9. AGE last birthday <u>—</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>21</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>L. Henry Willey</u>				14. MOTHER'S MAIDEN NAME: <u>Velma Lee Whaples</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>L. Henry Willey : Cambridge, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE		(A) <u>Congestive Heart Failure</u>				<u>36 hours</u>	
ANTECEDENT CAUSE (S)		(B) <u>Congenital Heart Disease, type unknown</u>				<u>Life</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>upper respiratory infection</u>				<u>2 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>11-10-1954</u> , to <u>4-1-1955</u> , that I last saw the deceased alive on <u>4-1-1955</u> , and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edridge H. J. Offord</u>		M. D. <u>Cambridge, Md.</u>		DATE SIGNED <u>4-6-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-3-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Dorchester Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Cambridge, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-3-55</u>		REGISTRAR'S SIGNATURE <u>John Mace, Jr. M.D.</u>		24. FUNERAL DIRECTOR <u>LeCompte Funeral Service</u>		ADDRESS <u>Cambridge, Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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VS. A15—10-53

BUREAU V. S.

APR 15 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3634

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03634

Reg. Dist. No. 116

1. PLACE OF DEATH COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Dorchester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cambridge		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Vienna - Rural	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cambridge - Maryland Hospital		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Elizabeth (Middle) B. (Last) Wongus	4. DATE OF DEATH (Month) (Day) (Year) April 14 1955	
5. SEX Female	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH June 12, 1880
9. AGE last birthday 74 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Vienna, Maryland, R.F.D.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Camper		14. MOTHER'S MAIDEN NAME Annie Chase	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-14-7245	
17. INFORMANT AND ADDRESS Mrs. Irene Pinder, Vienna, Maryland		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 Immediate cause (a) Cardiac Decompensation			
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Myocardial infarction			
(c) Arteriosclerotic heart disease			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 54 , to 14 April , 19 55 , that I last saw the deceased alive on 13 April , 19 55 , and that death occurred at 8:05 m., from the causes and on the date stated above.			
SIGNATURE John Mace Jr. M.D.		ADDRESS Cambridge, Md.	
DATE SIGNED 14 April 55			
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE THEREOF April 17, 1955	
NAME OF CEMETERY OR CREMATORY Saul Landing Cemetery		LOCATION (City, town, or county) (State) Near Vienna, Maryland	
DATE REC'D BY LOCAL REG. 4-17-55		24. FUNERAL DIRECTOR J.J. Frampton and Son, Federalsburg, Md.	

BUREAU V. S.

APR 20 1955

RECEIVED